Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2731AGC	A. BUILDING _____ B. WING _____	12/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCA'S RETIREMENT HOME CARE	3805 REDWOOD STREET LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted in your facility on 12/2/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 total beds. The facility had the following category of classified beds: Category 2, 6 beds. The facility had the following endorsements: Residential facility which provides care to persons with mental illnesses, Residential facility which provides care to elderly or disabled persons Residential facility which provides care to mentally retarded The census at the time of the survey was 5. Five resident files were reviewed and 3 employee files were reviewed. There were no complaints investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE